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1.0 Description of the Service

The Program of All-Inclusive Care for the Elderly (PACE) is a unique model of managed care service delivery for the frail elderly living in the community. Most PACE participants are dually eligible for Medicare and Medicaid benefits, and all are certified eligible for nursing home placement according to the standards established by the state Medicaid agency.

The PACE program utilizes monthly capitated payments from Medicare and/or Medicaid to provide an integrated and comprehensive medical and social service delivery system for elderly individuals who prefer to receive services in the community rather than at a nursing care facility. PACE uses an interdisciplinary team to provide services at the PACE Center and to case manage the care and services provided to PACE participants by community providers.

The PACE program is located in the community and centered in a certified adult day health program. Services are provided on site and supplemented by in-home and referral services in accordance with each participant's needs.

2.0 Eligible Recipients

2.1 Eligibility Requirements for Participants

2.1.1 Financial Eligibility

To qualify for PACE, an individual must meet financial eligibility requirements for Long-Term Care Medicaid/PACE established for North Carolina Medicaid by the Division of Medical Assistance (DMA), as documented in 10A NCAC 21B.0101 and .0102.

2.1.2 Federal Eligibility Requirements

As required by 42 CFR 460.150, an individual must meet the following requirements to be eligible to enroll in PACE:

a. be 55 years or older;
b. reside in an approved PACE service area;
c. meet the state's Medicaid criteria for nursing facility level of care; and
d. be safely served in the community.

2.2 EPSDT Special Provision: Exception to Policy Limitations for Recipients under 21 Years of Age

42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

PACE does not serve recipients 21 years of age or younger; therefore, the provisions of 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act) relating to Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for children do not apply.

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3.0 When the Service Is Covered

3.1 General Criteria

Medicaid pays a monthly capitation fee to the PACE organization for eligible recipients participating in the PACE program when the service is medically necessary and

a. the individual meets Medicaid's requirements for nursing facility level of care, as determined by Medicaid screening (see **Section 5.5**);
b. the level of care determination is confirmed by a full medical assessment conducted by the PACE organization (see **Section 5.6**); and
c. the recipient meets the requirements indicated in **Section 2.1.**

3.2 Continuation of Service in the Absence of Criteria

A PACE participant may be deemed eligible if, following enrollment, the participant no longer meets nursing facility level of care criteria; but the state determines, in accordance with applicable regulations, that the absence of PACE services would result in a deterioration of the individual's health status to the point where the individual would again qualify for PACE within a six-month period following disenrollment.

4.0 When the Service Is Not Covered

Medicaid does not pay a monthly capitation fee to the PACE organization for recipients when

a. the recipient does not meet the eligibility requirements listed in **Section 2.1;**
b. the recipient does not meet the medical necessity criteria listed in **Section 3.0;** or
c. the service unnecessarily duplicates another provider's service.

5.0 Requirements for and Limitations on Coverage

5.1 Prior Approval

No prior approval is required for PACE enrollment; however, the need for nursing facility level of care must be confirmed by the state's Level of Care Review and the PACE organization's assessment as described in **Section 5.6.**

5.2 Enrollment Requirements

5.2.1 Enrollment Agreement

In accordance with 42 CFR 460.154, if the participant meets the eligibility requirements and wants to enroll, s/he must sign an enrollment agreement that contains, at a minimum, the following:

a. Mission and philosophy
b. Eligibility criteria
c. Enrollment and disenrollment procedures
d. Participant rights and responsibilities
e. Benefits and coverage

f. Multidisciplinary care team
g. Consumer advisory committee
h. Contract providers
i. Emergency and urgent care
j. Out-of-service-area coverage
k. Prescription drug coverage
l. Grievance and appeals procedures

5.2.2 Enrollment Documentation

In accordance with 42 CFR 460.156, the PACE organization must give a participant, upon signing the enrollment agreement, the following:

a. A PACE membership card
b. A copy of the enrollment agreement
c. Emergency information to be posted in his or her home
d. Stickers for the participant's Medicare and Medicaid cards, as applicable

5.2.3 Effective Date of Enrollment

In accordance with 42 CFR 460.158, a participant's enrollment in the program is effective on the first day of the calendar month following the date the PACE organization receives the signed Enrollment Agreement.

5.2.4 Continuation of Enrollment

In accordance with 42 CFR 460.160, the PACE enrollment continues until the participant's death, regardless of changes in health status, unless the participant voluntarily disenrolls in accordance with 42 CFR 460.162, or is involuntarily disenrolled in accordance with 42 CFR 460.164.

5.3 Sole Source of Services

As indicated in 42 CFR 460.154, each individual enrolling in PACE must accept PACE as his/her sole source for services. This requirement must be included in the PACE Enrollment Agreement and the individual or legally responsible person must acknowledge acceptance of this requirement by signing a form approved by DMA.

5.4 Participant Disenrollment from PACE

5.4.1 Voluntary Disenrollment

In accordance with 42 CFR 460.162, a PACE participant may voluntarily disenroll from PACE at any time without cause.

5.4.2 Involuntary Disenrollment

In accordance with 42 CFR 460.164, a PACE participant may be involuntarily disenrolled for any of the following reasons:

a. The participant fails to pay, or to make satisfactory arrangements to pay, any premium due to PACE organization after a 30-day grace period.
b. The participant engages in disruptive or threatening behavior.
c. The participant moves out of the PACE program service area or is out of the service area for more than 30 consecutive days, unless the PACE organization agrees to a longer absence due to extenuating circumstances.

d. The participant is determined to no longer meet the state Medicaid nursing facility level of care requirements and is not deemed eligible.

e. The PACE program's agreement with the Centers for Medicare and Medicaid Services (CMS) and the state administering agency is not renewed or is terminated.

f. The PACE organization is unable to offer health care services due to loss of state licenses or contracts with outside providers.

5.4.3 Procedures for Involuntary Disenrollment

In the event that a participant is involuntarily disenrolled, federal regulations (42 CFR 460.164) require that the PACE organization

a. adequately document the acceptable grounds for disenrollment and provide any additional documentation requested by DMA and

b. continue to provide services until the effective date of disenrollment.

Both DMA and the PACE organization must assist the individual in obtaining other care and services to meet his or her medical, functional, psychological, social, and personal care needs.

5.4.4 Effective Date of Disenrollment

a. The PACE provider organization is required to ensure that the disenrollment date is coordinated between Medicare and Medicaid for individuals who are dually eligible (42 CFR 460.166).

b. The PACE participant must continue to use, and the PACE organization must continue to provide, PACE services up to the effective date of termination (42 CFR 460.164).

c. The disenrollment date should not become effective until the participant is appropriately reinstated into other Medicare and Medicaid programs and alternative services are arranged (42 CFR 460.164).

5.5 Nursing Facility Level of Care Review

5.5.1 Initial Level of Care Review

In accordance with 42 CFR 460.152(a)(3), prior to enrollment in PACE, Medicaid must certify that the PACE applicant meets the state's nursing facility level of care criteria.

5.5.2 Annual Level of Care Review

As required by 42 CFR 460.152(a)(4), the PACE organization must submit the Long-Term Care Uniform Screening Tool each year to verify that the enrollee continues to meet nursing facility level of care requirements.

5.6 Assessments

5.6.1 Physical, Functional, and Psychosocial Assessment

Following certification by Medicaid that an eligible recipient meets nursing facility level of care requirements, the PACE interdisciplinary team (IDT), under the direction of the PACE medical director and in accordance with 42 CFR 460.104, must conduct a comprehensive assessment of the applicant, to include the following:

a. Physical examination and health status review
b. Cognitive status
c. Mental health needs
d. Need for specialized therapies, including occupational and physical therapy
e. Need for ancillary services
f. Living arrangements and social support systems
g. Nutrition
h. Recreational therapy
i. Home care needs
j. Assistive technology
k. Barriers related to transportation

5.6.2 Health and Safety Assessment

The PACE program must also conduct a comprehensive health and safety assessment to ensure that the applicant's health, safety, or welfare will not be jeopardized by living in the community. As required by 42 CFR 460.152(a)(4), the assessment must include

a. An on-site evaluation of the applicant's residence
b. An evaluation of the applicant's social support system, including the willingness and capabilities of all informal caregivers
c. An evaluation of whether the applicant can be safely transported to the PACE center

5.7 Plan of Care

Following the required assessments, the PACE program must develop a plan of care on a form approved by DMA and submit it to DMA for approval. As required by 42 CFR 460.106, the plan of care must be updated and submitted to DMA for approval at least annually.

5.8 Benefit Package

As specified in 42 CFR 460.90 and .92, the PACE benefit package for all participants, regardless of the source of payment, must include the following:

a. All Medicaid-covered services, as specified in the State's approved Medicaid plan
b. Multidisciplinary assessment and treatment planning
c. Primary care, including physician and nursing services
d. Social work services
e. Restorative therapies, including physical therapy, occupational therapy, and speech-language pathology services
f. Personal care and supportive services
g. Nutrition counseling
h. Recreational therapy
i. Transportation
j. Meals

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k. Medical specialty services including, but not limited to, the following:
   1. Anesthesiology
   2. Audiology
   3. Cardiology
   4. Dentistry
   5. Dermatology
   6. Gastroenterology
   7. Gynecology
   8. Internal medicine
   9. Nephrology
   10. Neurosurgery
   11. Oncology
   12. Ophthalmology
   13. Oral surgery
   14. Orthopedic surgery
   15. Otorhinolaryngology
   16. Plastic surgery
   17. Pharmacy consulting services
   18. Podiatry
   19. Psychiatry
   20. Pulmonary disease
   21. Radiology
   22. Rheumatology
   23. General surgery
   24. Thoracic and vascular surgery
   25. Urology

l. Laboratory tests, X-rays, and other diagnostic procedures

m. Drugs and biologicals

n. Prosthetics, orthotics, durable medical equipment, corrective vision devices such as eyeglasses and lenses, hearing aids, dentures, and repair and maintenance of these items

o. Acute inpatient care, to include
   1. Ambulance
   2. Emergency room care and treatment room services
   3. Semi-private room and board
   4. General medical and nursing services
   5. Medical-surgical intensive care and coronary care unit
   6. Laboratory tests, X-rays, and other diagnostic procedures
   7. Drugs and biologicals
   8. Blood and blood derivatives

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9. Surgical care and anesthesia
10. Oxygen
11. Physical, occupational, and respiratory therapies and speech-language pathology services
12. Social services

p. Nursing facility care, to include
1. Semi-private room and board
2. Physician and skilled nursing services
3. Custodial care
4. Personal care and assistance
5. Drugs and biologicals
6. Physical, occupational, and recreational therapies
7. Speech-language pathology, if necessary
8. Social services
9. Medical supplies and appliances

q. Other services determined necessary by the IDT to improve and maintain the participant's overall health status

5.9 In-Home and Referral Services

As required by 42 CFR 460.12, the PACE program must arrange for all in-home and referral services that may be required for each participant. In-home and referral services are furnished by community providers under contract to the PACE program.

5.10 Emergency Care Services

The PACE program must provide emergency care services in accordance with 42 CFR 460.100.

5.10.1 Emergency Services Care Plan

The PACE program must establish and maintain a written plan for handling medical emergencies at the PACE Center and when the PACE participant is not at the PACE Center. The Plan must include procedures to access emergency care both in and out of the PACE Service Area. The PACE program must ensure that participants and caregivers know when and how to access emergency care services when not at the PACE Center.

5.10.2 Access to Emergency Care

In the case of a medical emergency, the PACE participant has the right to access the closest and most readily accessible qualified provider, in or out of the PACE service area, including hospital emergency room services.

5.10.3 Out-of-Service-Area Emergency Care

Emergency care while the PACE participant is out of the service area is covered by the PACE program and no prior approval is required.

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5.10.4 Out-of-Service-Area Follow-up Care

Urgent care and care furnished to the PACE participant to stabilize his/her condition after a medical emergency that is provided outside the PACE service area must be prior approved by the PACE program.

5.10.5 Retrospective Reviews of Emergency Care

Evaluation of the participant's decision to use emergency services must be based on the prudent layperson standard and no higher standard may be adopted by the PACE program.

5.10.6 Cost of Emergency Care

Charges for all emergency care must be paid by the PACE program.

6.0 Providers Eligible to Bill for the Service

6.1 PACE Regulations

The PACE program must comply at all times with the federal PACE regulations specified in 42 CFR Parts 460, 462, 466, 473, and 476 Medicare and Medicaid Programs; Program of All-Inclusive Care for the Elderly (PACE); Program Revisions; Final Rule.

6.2 Certification Requirements

As required by N.C. G.S 131D-6 and 10 NCAC 06S, the PACE center must be certified as an adult day health program by the North Carolina Division of Aging and Adult Services.

6.3 Capitated Payment and Amounts

6.3.1 Payment for PACE Participants

The state provides a prospective monthly capitated payment for each PACE participant who is eligible for Medicaid assistance, in accordance with Section 1934(d) of the Act and 42 CFR 460.180. The capitation payment amount is specified in the PACE program Agreement and is based on the amount the state would otherwise have paid under the State plan if the recipients were not enrolled in PACE.

6.3.2 Payment for Medicare and Medicaid Dually Eligible Recipients

In accordance with 42 CFR 460.180 and .182, a PACE program is eligible to receive monthly capitated payments from Medicaid for recipients who are Medicaid eligible or dually eligible for both Medicare and Medicaid when

a. the organization has been approved by DMA as a PACE provider;
b. the organization has been approved by CMS as a PACE provider; and
c. all parties have properly executed the three-way agreement between CMS, DMA, and the PACE organization.

Because the PACE program is designed to serve individuals who are Medicare and Medicaid dually eligible, the PACE program must accept the capitation payments from Medicare and Medicaid as payment in full for all services required by the participant.

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6.3.3 Private Pay Participants

Federal regulations (42 CFR 460.186) allow the PACE organization to accept private-pay participants and to collect a premium from individuals who are Medicare-only or Medicaid-only beneficiaries.

7.0 Additional Requirements

7.1 Reports to DMA

Sections 1894 and 1934 of the Social Security Act (the Act) allows states to impose additional requirements on PACE programs. As such, DMA requires PACE programs to provide copies of all patient Physical, Functional, and Psychosocial Assessments, and Health and Safety Assessments, and other reports and documents as may be appropriate to DMA on a form or in a format approved by DMA.

7.2 Provision of Service

7.2.1 Service Area

As required by 42 CFR 460.32(a), the PACE program must define its service area. The service area must be approved by DMA and CMS.

7.2.2 PACE Center

As defined by 42 CFR 460.98(d)(1), the PACE program must establish an adult day health facility that includes a primary care clinic, areas for therapeutic recreation, restorative therapies, socialization, personal care, and dining, which serve as the focal point for coordination and provision of most PACE services.

7.2.3 Interdisciplinary Care and Case Management

As required by 42 CFR 460.102(b), the PACE program must establish an IDT to provide care and case manage all of the services provided or arranged by the PACE program for each participant. Consistent with federal regulations, the PACE program IDT must be comprised of the following members:

a. Primary care physician
b. Registered nurse
c. Masters level social worker
d. Physical therapist
e. Occupational therapist
f. Recreational therapist or activity coordinator
g. Dietitian
h. PACE center manager
i. Home care coordinator
j. Personal care attendant
k. Van driver

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7.3 Quality Assessment and Performance Improvement

As required by 42 CFR 460.134, the PACE program must develop, implement, maintain, and evaluate an effective data-driven quality assessment and performance improvement (QAPI) program. The QAPI program must, at a minimum, include mechanisms to

a. Receive and address patient and patient caregiver complaints and grievances and, when necessary, take appropriate corrective action(s)
b. Measure and evaluate patient and patient caregiver satisfaction with care and services
c. Collect and analyze cost and utilization data
d. Collect and analyze patient outcome data on both the individual and organizational level
e. Measure the effectiveness and safety of care and services
f. Maintain and submit quarterly data to CMS and DMA on each of the following nine data elements:
    1. Routine immunizations
    2. Grievance and appeals
    3. Enrollments
    4. Disenrollments
    5. Prospective enrollees
    6. Re-admissions
    7. Emergencies (unscheduled care)
    8. Unusual incidents
    9. Deaths

7.4 Medical Record Documentation

The PACE organization must maintain a single comprehensive medical record for each participant. At a minimum, the medical record must include the information and documentation specified in 42 CFR 460.210.

7.5 Medical Record Retention

In accordance with 42 CFR 460.200, medical records must be maintained in an accessible location for at least six years after the last entry date or six years after the date of disenrollment.

Note: If litigation, a claim, a financial management review, or an audit arising from the operation of the PACE program is started before the expiration of the retention period, the PACE organization must retain the records until the completion of the litigation or resolution of the claims or audit findings.

7.6 Claims and Encounter Forms

7.6.1 Claims

The PACE organization does not submit claims to Medicare or Medicaid for any service provided to PACE enrollments, in or out of the service area.

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7.6.2 Encounter Forms

The PACE program is not required to submit encounter forms to Medicare or Medicaid.

8.0 Policy Implementation/Revision Information

Original Effective Date: February 1, 2008

Revision Information:

Date	Section Revised	Change

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Attachment A: Claims-Related Information

A. Claim Type

Not applicable.

B. Diagnosis Codes

Not applicable.

C. Modifiers

Not applicable.

D. Billing Units

Not applicable.

E. Place of Service

Not applicable.

F. Co-payments

Not applicable.

G. Reimbursement

Not applicable.